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ABSTRACT

Described is the Therapeutic Preschool, a community based program with university affiliations serving two classes of five emotionally disturbed preschool children and their families. Noted are diagnostic, research, and community service aspects of the program. Focused on is the role of the social worker in the parent education component. Included are a listing of tests and their purposes in the standard diagnostic procedure and a case study of a 5-year-old boy. Discussed is the program's demonstration aspect which is reported to include the training of day care center staff and plans to provide inservice training to pediatric residents, nursing students, and mental health agents. The role of the teacher in the preschool is examined in terms of assessment, therapy, intervention, and consultation. (DB)

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The Therapeutic Preschool

A Service, Research and Demonstration Project

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The Therapeutic Preschool, a community based organization with university affiliations, is a treatment, research and demonstration project serving disturbed preschool children and their families. Begun in 1968 as an alternative treatment model to individual psychotherapy, the project featured a small group classroom setting for troubled preschoolers of average intelligence and a program for parents that combined weekly observation sessions with child-centered family treatment. Project teachers had responsibility for integrating children's cognitive and affective needs. Since our treatment model was psychoeducational the project provided individually planned care for each child within a structured group setting. Mastery, a knowledge of each child's developmental levels, self esteem all became important words to teachers, social workers and parents that first year of our history. Early goals for our class of five children and their parents seemed quite simple:

(1) to return children to normal school settings as quickly as possible

(2) to institute home programs for all parents and children in the Preschool

(3) to follow up families treated by the Project

Ancillary goals included providing training for psychiatric and social work students, and establishing a workable research design for the project.

Our early success was encouraging. We were helping these children to adjust better to themselves and their environment. Families were gaining a broader understanding of their child's strengths and weaknesses, and parental expectations and responses became more fruitful. Our limitations, however, were as clear as our success as an early intervention model. We had a largely middle class, white, university population. We served only children who ranged in age from

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four to six. We did little consistent work with community day care centers that served our children, in most cases, the other half of the day that we were not seeing them. Our understanding of parent's needs received a rude awakening when we discovered that a home program listing specific timed activities was worthless if parents didn't know how to play or didn't want to interact with their children. The program made little provision for the child with learning disabilities, although we paid lip service to him. We were still quibbling about primary emotional disturbance vs secondary orgaincity and vice versa, while the needy children and families in question waited in the wings. Finally, we were spending approximately $40,000 a year on five children and their parents. Training was sporadic, at best, and our research design was extremely nebulous.

In 1971 the Preschool staff became part of a consultation team serving preschools and daycare centers in the Chapel Hill area. We discovered dedicated daycare directors and teachers, who despite poor pay and long hours, were eager to improve their centers and deal more effectively with problem children. For over a year, these part-time consultants paid brief but regular visits to a small number of community child care centers. Their work was meaningful but limited. Paucity of time and the notion that these centers needed help not only in referring children to the Therapeutic Preschool for treatment, but in managing atypical children within their own sites, led us to apply for an expansion grant from the National Institute of Mental Health. In summer, 1972, our funding was approved and the Therapeutic Preschool became a part of Project Early Aid. Project Early Aid comprises a staff of four full and one half-time consultants to day care as well as the Therapeutic Preschool which now holds two classes daily and provides an extended diagnostic service. Day care consultants last year provided service to 800 children - this included rudimentary screening, parent education, program and administration consultation, as well as

formalized instruction for day care workers in curriculum and child development. The Therapeutic Preschool treated 10 children daily, their parents weekly for eleven months, as well as 40 families for diagnostic work-up.

The need for our project to expand its diagnostic and treatment facilities became more apparent as our knowledge of the community increased. Our population became more heterogeneous, the children referred to us through Project consultants more diverse. Previously, informal testing sessions with a child and traditional psychiatric interviews with the child and his parents seemed to constitute an adequate diagnostic process for families referred to the Preschool for treatment. The more diverse our referrals became, however, the more simplistic and inadequate our diagnostic service became. What about the child with learning disabilities? What of the children who had a variety of problems, but for one reason or another remained full-time in their day care centers? What about families who were shuffled from one treatment center to another because their preschool child didn't fit into a simple category, but had multiple problems? Our project was faced with the choice of remaining as we were - a perfectly respectable psychoeducational treatment center, or expanding our facilities to meet the needs of the community. Our staff of seven Preschool workers turned their attention to a more suitable diagnostic process. Formalized tests to assess competence in conceptual, language and perceptual skills were adopted. More family-oriented interviews were established. A monthly diagnostic group was attempted. Visits to referring day care centers became routine to observe the child in his school setting. Projective testing was added to the diagnostic battery. Liaison was established with disciplines such as neurology, occupational, speech and physical therapy, enabling the Preschool to offer such evaluations under the aegis of our Project, with little or no additional cost to parents. Post-diagnostic recommendations began to be formalized and made

more specific, so that day care center teachers would receive appropriate intervention techniques for working with the children they referred.

As the diagnostic procedure became more comprehensive, treatment procedures came under closer scrutiny. Children with specific learning disabilities as well as behavior disorders became more appropriate to our setting. We stopped caring what label most adequately described them, and started investing our energies into devising the most comprehensive treatment plan possible for them. Although our facilities are not adequate to serve children with gross physical handicaps or severe developmental disabilities, there are now two community projects in existence to whom we may refer such children. Children and families treated at the Preschool are assured that we will try to meet their needs as best we can within our basic framework. The children must be at school five days per week. Their parents must participate through observation on a weekly basis. Beyond that, our staff is trying to become more flexible. Home visits are now being made. Work with foster parents is being undertaken. Individual work is carried on with families on the waiting list, as well as families who have left the traditional project treatment. Plans are being formulated for treating younger children, high-risk children, parents who are in acute stress situations, abused children. These are distant goals as long as our staff remains small. But we have, at least, in striving to avoid insularity, become less smug.

As I mentioned earlier, ongoing research conducted at the Preschool began in a sporadic fashion. We started out by attempting to measure everything - attitudes, maturity, expectations in parents; symptomatology, social and cognitive gains in children. Since our researchers were then only part-time staff, unequal piles of date were gathered which established little besides evidence that we would be hard put to find a complete set of material on any subject in the study. Trial and error plus the addition of a full time research assistant to the program have led

us to our present design. Currently, we are investigating children's behavioral improvements at the Preschool against a matched sample. The Project also attempts to determine whether Preschool parents, through treatment, adopt a positive change in attitude about their children. A more detailed description of the Project's research component will be provided later in our presentation.

I have described thus far a service and research center that aims at serving the community from which it operates. But our community is larger than the families and child centers with whom we come into direct contact. Our community responsibilities include speaking for a child to his environment. Of equal importance is our responsibility to transmit our goals, efforts and assessments in behalf of young problem children to that community. It is of limited valuc to treat children as a collection of labelled, assembled parts. We must demonstrate the conviction that children are whole individuals to others. Consequently, we strive to reach community groups working with young children and their families, to show them what we are doing and how to do it, in the hope that someday in what may be an ideal world, our Project and programs like it may be assured obsolescence.

We have now concluded the first part of our session with you today. After a short break in order to stretch our legs and rearrange the room, our workshop will begin. Maxine, Eloise, a[illegible]e will be on hand to answer any questions you might have about social work and demonstration, and share with you some of the materials they've brought with them. Sam will be over at the research table. Jo, Carol, and Lois have a number of things to share at the teacher's table. We hope that you will come and talk with us. Although we are proud of our Program and our acheivements, it was not our intention to present to you a project that is perfect. We came to CEC to share our ideas, and to learn from you, our colleagues. Thank you for being here with us and we'll see you at the workshop.

ROLE OF SOCIAL WORKER AT TPS

Although the main emphasis is child focused in the TPS, the contract made with parents for the father and mother to attend mandatory weekly observation sessions emphasizes our conviction as social workers that without parents actively participating in their child's treatment program in order to strengthen the family unit, little lasting change can be maintained. The child's relationship with his parents and siblings and the time spent with them however large or small is the most meaningful part of his day. The child's self-image and ideals are internalized from the familial experience.

We feel effective child treatment must be integrated with the parents treatment to be successful. A supportive, functional approach is used with those in parenting and caretaking roles of children enrolled in TPS. Our approach to parents is individualized to their assessed needs, strengths, and weaknesses.

The structure of parent treatment involves the parents attending the preschool for at least one hour a week to observe their child in the Preschool setting. By seeing their child in the group setting, parents can relate the effect of peer group pressure, and observable problem behaviors of their child sometimes never exhibited in the home. The child's problems experienced with his parents at home become dramatized in his conflicts with the teacher-therapists in the classroom who set limits, frustrate the child, reward him and control him. The teacher-therapists set models for parents to follow in dealing with the child's problematic behavior. However, we as social workers are always engaged in the ongoing process of evaluating and relating to the parents moods, needs, stresses both internal and environmental in assessing whether a parent can effectively model a treatment program set by the TPS teacher-therapists for their child.

It is of utmost importance that the teacher-therapists as well as others in caretaker roles, with the child be aware of the parents ability or inability to utilize the suggested interventions effectively. We communicate to the teacher-therapists valuable information learned from parents regarding the child's behavior at home which is most concerning to the parents. Only by providing this link between the parents and teacher-therapist can the TPS staff and families (teachers, social worker, and parents) work together to attempt to make the most effective treatment program for the child.

Our supportive interventions for families are numerous and varied. Attempts to lessen environmental stress for the child's family include assisting a parent in making contact with a department of social welfare, public health agency, helping to arrange transportation, day care placements, arranging additional speech therapy, physical therapy evaluation and treatment if indicated. If parents' marital conflicts or personal problems are interferring with their ability to assume better parenting roles, additional appointments for help in these areas are offered by us.

We try to help parents have more successful and pleasurable experiences with their children. This is done by encouraging parents in their ideas for corrective interventions or setting up behavioral programs for bedtime routine, controlling aggressive behaviors, etc. Again, I would like to stress that these concrete suggestions are made in relation to the parent's interests and strengths to utilize them consistently at the appropriate times with their child.

When parents are supported in learning better parenting techniques without fear of critism of attacks on their own personality or made to feel inadequate by teacher's demands on them, they feel freer to try new and hopefully effective interventions and communications with their children. When the TPS teachers find interventions that work for children in our classroom, they do

expect parents to be able to institute them effectively at home and are frustrated when this does not happen. An important part of the social workers role is to help teachers with their feelings of frustration and to help them develop more realistic expectations for parents' abilities to intervene with their children. While our main focus is on the child in the family unit exhibiting the most deviant behavior, often other children in the family are presenting problems to the parents as well. These are discussed and we see a generalization of better parenting techniques being utilized in the total family unit.

We find that when parents needs are acknowledged and supported they have more energy and willingness to invest themselves in enhancing their child's development.

We help integrate the child's treatment program at the TPS with the child's day care, nursery school or public school placement by meeting regularly with his other teachers. It is important we try to help DCC staff members with the feelings they experience toward parents of children enrolled in our program. Often these parents are difficult, demanding, defensive, and angry; and arouse corresponding anger and frustration in the DCC staff members. We try to help these alternate caretakers be aware of the strengths, weaknesses of parents, and stresses they are enduring. It is important for parents to be seen as people with their own problems and not just as "bad parents". DCC staffs may develop some understanding and empathy for the parents situation as well as the child's.

As we plan future expansion of services at TPS, we hope to offer parent treatment groups, PET sessions, HELP lines, parent information and referral groups. These ideas for services emerged from voiced community needs, questions from parents of children involved in TPS, etc. This will be commented on in more detail in the demonstration presentation.

We feel committed to the premise that you cannot define or treat a

disturbed preschool child outside the context of his whole environment.

I have not focused on the social worker's role in the diagnostic process; we will have an opportunity to discuss it during the workshop period.

Enclosed is a description of the Diagnostic process at the Therapeutic Preschool and a case study of one referral for diagnosis and recommendations. The case study is presented in barest form. This is by no means all the information we had available on the child, however, it is a good example of the various steps, each adding new information, which our staff takes to arrive at a functional diagnosis, and hopefully, helpful recommendations.

If you have any questions or suggestions please feel free to ask or write:

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STANDARD DIAGNOSTIC PROCEDURE

TEST	PURPOSE
Intake, Social History	To assess strengths and weaknesses of child, parents, and family as a whole in addition to environmental affects.
Observation of child in regular school setting	To assess child's social and educational level of functioning within his normal setting.
Marianne Frostig Developmental Test of Visual Perception	Perceptual diagnosis with the following subtests: Eye-Motor Coordination, Figure Ground, Constancy of Shape, Position in Space, Spatial Relationships.
Gates-MacGinitie Reading Tests Readiness Skills	Divides the reading process into seven components, screening for auditory and visual deficits.
Lauretta Bender Visual Motor Gestalt Test	Visual Motor test with potential for projective diagnosis.
Goodenough Draw-A-Person Test	Perceptual, intellectual test, but used basically as a projective.
Play Interview The staff observes this interview	Used to aid in diagnosis of social-emotional development and concerns.
Family Interview The family participates for approximately one half hour with one social worker and one teacher as co-workers	Used to aid in understanding family dynamics.
Group Diagnostic Includes 5 or 6 preschoolers with two teachers in a classroom setting for 2 1/2 hours on two days	To assess both group and individual dynamics.
Wechsler Preschool and Primary Scale Of Intelligence or Stanford Binet	To assess intellectual functioning-relative strengths and weaknesses.
Staff Discussion	To integrate and interprete the results of testing and formulate recommendations.
Interpretive Interviews to parent and child and to day care center staff	To share and interprete results of diagnostic evaluation and make recommendations.

ADDITIONAL TESTING AVAILABLE

TEST	PURPOSE
Illinois Test of Psycholinguistic Learning Abilities	To assess visual and auditory language in terms of reception, association, and expression.
Projectives Children's Apperception Test Thematic Apperception Test	To assess personality dynamics - conflicts and defenses.
Kinetic Family	Further assessment of individual and family relationships through drawing and story telling.
Further diagnosis outside of the Therapeutic Preschool	For further diagnosis of specialized areas of concern, for instance, speech and language, physical therapy, neurology, etc.

Options available to children referred through the Therapeutic Preschool:

TPS placement
Tutoring by Day Care Center staff supervised by TPS staff or PEA*consultants
Integration of remedial material into Day Care Center activities, planned by TPS staff
Private tutoring arranged by PEA consultants or TPS staff
Short term family treatment
Referral to other appropriate programs for treatment

* Project Early Aid includes the Therapeutic Preschool and five consultants who serve local Day Care Centers.

Case Study of a Five Year Eight Month Old Boy

Referral Process and Intake
- Day Care Center Concerns:
  - Avoidance of perceptual tasks
  - Aggressive play
  - At times isolated and apparently "unhappy"
- Parental Concerns
  - Child's defeatist attitude
  - Educational difficulties
  - Confusion over "correct child-rearing techniques"

Initial Testing
- Family interview
  - Supportive interaction between mother and child
  - Child apparently anxious
    - avoided eye-contact
    - insisted on sitting in mother's lap
- Frostig
  - Slow work
  - Avoided eye-contact with tester
  - No marked high or low scores
- Gates-MacGinitie
  - Marked low scores on visual tasks
    - visual discrimination
    - visual motor coordination
- Draw-A-Person
  - Age appropriate drawings
  - Story about being ridiculed by friends
- Bender
  - One standard deviation below the mean
  - Constricted organization
  - Perseveration
- WIPPSI
  - Verbal score IQ 120
  - Performance Scale IQ 93
  - Child reluctant to leave mother
  - No spontaneous conversation with tester

Implications of Initial Testing
- Despite average performance on Frostig, there is evidence of a perceptual disability in areas of:
  - visual discrimination
  - visual motor coordination
- This disability and the child's apparent anxiety around visual tasks could be effecting his behavior in the classroom.

Questions
- Does a motor response interfere with the performance of a visually stimulated task?
- Is speed-of-visual learning interfering with perceptual performance?
- Should organic involvement be investigated?

Action Taken After Staffing
- ITPA scheduled to further define visual functions.

ITPA

Mean one year above age level
Visual tasks executed slowly
Untimed visual tasks (visual reception, visual association) five points below the mean
Timed visual tasks (visual closure, visual sequential memory) scored significantly below mean (6 or more points)
Manual expression significantly high
Significant lows in visual tasks on automatic level
Verbal expression and sound blending a full ten points above his mean

Implications

Speed of visual learning disability
No motor complication with visually stimulated tasks indicated by high manual expression score
Possibility of organic involvement indicated by lows on automatic level
Strong compensation and above average intelligence

Action Taken After Second Staffing and Parent-Child Interpretive:

(1) Private tutoring set up in Day Care Center focusing on disabilities.
(2) Day Care Center Staff to aid in compensation, by supplementing visual tasks with auditory cues.
(3) Early, supportive interventions and more structured play planned by Day Care Center Staff designed to offer appropriate alternative and alleviate child's isolation and acting-out behavior.
(4) Organic involvement not pursued. This decision was made to save parents and child any further anxiety related to testing, as any further information would not effect remediation plans.
(5) Further family assistance offered through TPS social work staff.

DEMONSTRATION

Prior to this year demonstration has been a more discussed than implemented idea due to lack of staff and formalized programming. As noted earlier, parents have been integrally involved in observation/modeling through our one way mirror since the preschool's inception. As the importance of involving all significant others in the child's environment became evident, the child's day care center teachers were also included in treatment planning through regularly scheduled observation/discussion sessions.

We quickly discovered that the day care center teachers did not want to relate solely to the needs of the particular child they were serving. When we attempted to focus upon those techniques most applicable to the defined problem child, they raised innumerable questions about how they might handle other children in their centers. Their concerns were very real to them although they lacked the sophistication to define specific problem areas. Just as we believe an effective treatment plan must also meet the needs of the parents, we believe that some system must be set up to encourage day care center staffs to (1) recognize early signs of emotional disturbance and (2) assume responsibility for inhouse programming.

We believed the most appropriate way to begin was to schedule the entire staffs of the day care centers to observe. Although our Project Early Aid consultants focus on teaching day care center staffs curriculum techniques and normal expectations for preschoolers, we wanted the day care staffs to view actual teacher-therapists using interventions, establishing goals and utilizing curriculum as a medium for treatment. We encourage their input by relating examples which might be within their population. We direct their attention to both successful and unsuccessful interventions with the intent that they note the particular emphasis we place upon the teacher's utilization of her own personality traits. To observe another teacher reacting under stress or attempting to unify the group when an individual

child might be upsetting her plans enables the day care center staffs to identify their frustrations. When they observe positive interactions they can relate to the satisfying experiences they feel when events go as planned. Most importantly we attempt to help them learn how to observe beginning symptoms of disturbance.

Many remark that our laboratory classroom--5 children, 2 teachers--lends itself to the maximazation of self. How could the day care center teacher with many more children possibly "catch" all behaviors? Our message to them is clear: whether there are 5 or 25, all is not lost when a teacher misses a cue. Emotional disturbance in preschoolers is a patterning of symptoms. A teacher must use her knowledge of herself throughout the day to provide a child with a living model of human behavior. When teachers risk involvement with children they must address themselves to their and the children's many differing moods. To better observe and learn to identify problem behaviors is important but to begin to understand how one's own being best serves for change and to assume that charge with its many ramifications is the most important.

In January we offered a night workshop to day care center staffs regarding timing of interventions. They were "pleased" to know "when" to intervene but continue to want to know "how". Through regularly scheduled observation sessions we can augment the consultants role of educating and training day care center teachers. Due to time committments-both ours and the staffs of the day care centers-no refined program of follow through has been worked out.

As we attempted to view these needs we also realized that the majority of our referrals come via our Project's consultant staff. Pediatricians who have much influence with parents and contact with large numbers of children have infrequently requested our services. Staff social workers have always assumed responsibility for communicating ongoing plans to the child's pediatrician but few calls were generated the other way. Since the Therapeutic Preschool is

situated within the greater university and medical center complex it is a practical notion to offer ourselves as an inservice training site to pediatric residents. Through observation and discussion we would hope to broaden the resident's experiental knowledge as well as provide him with more resource material for future practice. This is most contingent certainly upon their acceptance of us and willingness to divest themselves of the perpetuated hoax that children "grow out of their problems".

During this year we unwittingly assumed responsibility for increasing nursing students pediatric knowledge. A required course in their curriculum involves volunteering 2 1/2 hours time per week to an agency providing psychiatric services. Their heavy work schedules and the energy crisis necessitated that they seek out a facility within close distance. Thus they chose us. Although we had stipulated to the course instructor that no more than two could be adequately handled, we were deluged with nursing students. We agreed that 5 could come. Our research design does not permit psychiatric treatment from other than the teacher-therapist therefore the nursing students were assigned observation times to fulfill their time committments and fit into our limited schedules. Their course obligation was of first consideration, yet our concern that there were obviously unmet areas in their understanding of early childhood development convinced us to present a more formalized approach to observation. The students were asked to choose one child and identify the one behavior causing him most difficulty. Through focusing upon one child they have learned to identify dysfunctional patterns and how one can intervene to interrupt inappropriate behavior habits.

We intend to propose to the nursing department a brief, perhaps 6 week, 2 hour per week training course in early recognition and treatment. Again as with the pediatric residents our goal is to enhance their diagnostic abilities and build on the concept of prevention through knowledge.

To further exemplify the notion that happenstance can lead to plan, one day 3 teachers in search of a job found their way to the Preschool. Although there were no teaching vacancies it seemed an opportune time for them to view our classroom and learn how their academic knowledge could be applied in a psychiatric setting. Their questions both regarding utilization of curriculum as a therapeutic tool plus implementation of self techniques leads us to believe that the preschool could offer to the special education and early childhood education departments a planned observation/discussion course. We would emphasize how integration of disciplines and uniqueness of self are combined to effect the most comprehensive program. Teachers could feel free to expand upon their own experiences and learn how they stimulate the therapeutic process of a small group. This differs from a practicum in which the teacher is constantly being evaluated and would be a less threatening time for self reflection. Ours is not to show and tell but to provide information and practical assistance in using the most vital tool a teacher has: herself.

As childrens needs and rights become more recognized, mental health agents are being forced to take the initiative for both reviewing the inadequacies of existing services and for providing additional ones. Whether to serve preschoolers within the more traditional one-to-one or within a group depends upon how the community views its needs. Our affiliation with the Orange-Person-Chatham Mental Health Center establishes it as a model for children's services for our state. We believe that when behavioral problems manifest themselves within a peer group structure then they are best dealt with within the group process. We are constantly surveying the community and believe we are now beginning to be more responsive to its needs. For a treatment program to be effective we feel very strongly that the community should be accepting and be integrally involved in setting up planning. When we have had requests from mental health agencies who intend to establish therapeutic preschools we have voiced much concern that they reflect their community's

perception of such a service. This idea of total community involvement is essential.

We are planning to provide out reach services to all N.C. mental health centers who express interest in establishing preschools for emotionally disturbed children. Many people have felt that sheer observation of a child can provide enough information to plan a treatment program. When questions are raised about the importance of combining educational, and psychological testing with information regarding the child's social and developmental history we are committed to demonstrate and educate. We have determined that the majority of the children we have admitted to the Therapeutic Preschool have fairly uneven social and cognitive development and that many times a learning problem interferes significantly with a child's mastery of social skills. We will be of ongoing assistance to mental health centers in reviewing curriculum and screening mechanisms. Whatever is deemed most appropriate to emphasize a synethesized delivery of services will be incorporated.

We can be utilized as a training site for health professionals whether or not they are involved in direct delivery of services to preschoolers. There are social work and psychology trainees whose early child diagnostic skills need sharpening. Public health nurses, welfare workers and mental health personnel who receive greater understanding of the many variables influencing a child's development can institute more comprehensive planning in their agencies. As we strive to define and refine our program's strengths and weaknesses and try to incorporate the many grandiose notions we have, we must expand. Time and finances are realistic considerations and impediments. To date federal funding for personnel costs has not included additional positions. Both tuition and diagnostic evaluations are based upon a sliding scale and our current population can afford only the minimal charge. If we hope to establish a formal demonstration model and become a more vital training site our staff must increase. If we do not pursue all

possible avenues we will be negating what we most fervently believe: that early recognition and treatment are the building blocks of a more mentally healthy society. To challenge those persons in direct nurturing roles as well as those who serve as ancillary caretakers is not enough. We feel we must also provide some viable means for implementing change. Through information, demonstration and discussion both of our successes and failures and through educational input and emphasis upon integration of models we think we can offer more than a treatment model.

The role of the teacher at the TPS is currently undergoing evaluation and expansion. This is the result of an attempt to bring our implementation of treatment in line with the philosophy that the most successful treatment of a child necessitates the active involvement of the child, his parent(s), his teachers and the larger community. We believe that treatment of children with social-emotional problems should include the parents and community in the process of selecting goals, dealing with the problems and evaluating the child's progress. Until recently the teacher's expertise had been primarily used in the classroom to establish an individualized treatment plan, a plan that emphasized the utilization of peers and the group process. We are still committed to this form of specialized treatment within our laboratory classrooms. However we realize that a broader interpretation of our model places teachers not only in the classroom but outside the classroom in order to more realistically respond to the needs of the parents and the community. By examining our model and the roles of the teacher that correspond to it, we can ascertain just what teachers are doing at the TPS. Although we view our model as continuous and circular, I have broken it into three stages to facilitate a clearer understanding of the process involved and how this process begins. Slide 1 depicts our model. First comes the INITIAL ASSESSMENT PHASE which is then followed by the TREATMENT and the CONTINUED ASSESSMENT PHASES. By looking at slide 2 we can see that during the IAP the teacher functions in four roles, two located within the TPS setting and two outside the TPS which are referred to as OUTREACH activities.

Within the setting of the TPS the teacher has the roles of diagnostician and therapist. It is the diagnostician's responsibility to conduct a play interview with new referrals and to administer such formal tests as the Marianne Frostig Developmental Test of Visual Perception, the Gate-MacGinitie Reading Readiness Test, the Draw-a-Person, the ITPA and others.

For any given case it is the diagnostician's responsibility to recommend further evaluations that require speci ists. Recommendations for further evaluations are based on educational and psychological test information and on information from the child and the child's family history. In addition to work with specific referrals the diagnosticiar also examines newly marketed assessment instrumengs in order to sophisticate, that is improve the quality and range of our total diagnostic service. One teacher whose special interest is mutual-story-telling began seeing a child for individual sessions while the child was on a waiting list for the regular diagnostic. Because information gained during these sessions proved valuable during the later diagnostic, we are considering expanding our diagnostic process to include sessions of mutual-story-telling.

During the Initial Assessment Phase after the diagnostic evaluation is completed and the child has been placed in the TPS classroom, the teacher's m a in function is that of primary therapist. At this point in time all diagnostic and observational data on the child is used by the teachers to formulate a list of priority goals for the child in the classroom. At this time a limited number of mutual TPS, parent, and Daycare center goals for the child are also enumerated in order toestablish a consistent core treatment plan to be effected in each of these settings.

Outreach activities during the IAP consist of consulting and an educational screening at daycare centers. This move into the daycare centers is a relatively new direction for teachers and reflects an expansion of the IAP of our model beyond the walls of the TPS. It is in OUTREACH that we anticipate a great need for services we can provide. Traditionally the teacher consulted daycare staff on identification of specific children that needed special evaluations. In fact this early consultation helped to generate the Project Early Aid Consultant

program mentioned by Ms. Woodside. Presently we are still interested in educating daycare staff about the observation and assessment of children but we are accomplishing this less often through consultation and more often through workshops, demonstrations, community college courses and inservice training at the centers. In other attempts to provide a service to other community needs individual teachers are experimenting with special projects.

One teacher set up the educational screening program that is available to daycare centers. The rationale for such a program is that hopefully this kind of early assessment of all children will give recognition and emphasis to the importance of the concept of prevention and lead to earlier identification of children needing special treatment.

We have just seen the different roles that the teacher fills at the TPS during the IAP. If we look at the Treatment Phase of our model we can see the continuatio of the roles of therapist and consultant and the addition of new roles.

Now let's look at what the teacher is doing while located at TPS. There are two 1/2 day classes for e.d. preschoolers - a class for 4 year olds in the morning and a class for 5 and 6 year olds in the afternoons. These children may exhibit developmental lags or learning disabilities but the predominant reasons for their placement in our classroom is the existence of emotional and/or social problems that interfer substantially with their functioning. They spend 2 1/2 hours at TPS and the rest of the day in centers. Two teachers in each classroom are the child's primary therapists. They work as a team, integrating their viewpoints and skills, and utilize a variety of treatment techniques. Because many interventions are coordinated with parents and the child's daycare cen interventions are selected only after consideration of the following three points: (1) What is the goal for the child? (2) Who will be implementing the technique? and (3) Where will this implementation take place? Each of these considerations is very

important in the choice of any treatment technique. It is apparent that goals can vary along such dimensions as short or long term goals, individual or group goals, behaviorally specific or generally defined goals and so on. However, A responsible choice of technique can be made only after the goal is clearly defined.

Once the goal is defined, it is necessary to consider who will be implementing the treatment technique. It is expected that the teachers can carry through a complicated treatment plan, integrating different goals and continuously assessing performance. On the other hand it would be unrealistic to expect most parents to carry through the same complicated plan. It is at this point in treatment planning that the importance of communications between the teachers and the social workers becomes apparent. Because the social worker best knows the skills and motivations of the parents she can ably predict the success of any given treatment plan and can facilitate the formulation of a plan appropriate to the abilities of the parents. Because the social worker is in regular and frequent contact with the parents she is able to clarify any questions the parents have about the plan and to judge how well they are carrying it out.

The third point to consider is where the treatment technique will be implemented. In the classroom the treatment can include manipulation of time, materials and space in any desired combination whereas at home parents may find that a simple manipulation of space is very difficult because of their living conditions. In the classroom teachers can utilize techniques requiring a team approach or an individual therapist, while this choice might be impossible for a small staffed day care center or a single parent.

The teacher has also functioned as a supervisor to special education trainees at The supervisor guided the trainee through a graduated program beginning with learning observational skills and leading up to his active participation as a teacher-therapist in the class.

Individual teachers have been able to pursue special interests which relate to the Treatment Phase of our model. One teacher used a special six week summer session to conduct a small research project within the classroom. This program demonstrated the successful utilization of a group contingency reinforcement system to establish and maintain group interaction among four five year old boys. The teachers were able to collect and interpret all the data within the classroom without jeopordizing other goals for the children and without adding to the teacher's usual work schedule.

In Outreach Activities related to the Treatment Phase of our model teachers have mainly acted as consultants and tutors. This tutoring and/or consultation is usually done as a diagnostic follow-up or in conjunction with a child's ongoing treatment in the TPS classroom. For example, if a child is enrolled in the TPS one teacher is responsible to observe him at his daycare center and suggest interventions and/or suggest precisely how and when to use an intervention effectively. This outreach by TPS teachers often has a positive side effect. We often see the kind of interventions used in the daycare centers change and sometimes we even influence their curriculum planning and classroom design.

Other outreach activities to the parents and community involve workshops, demonstrations, and training seminars focusing on application of treatment technique In most of these activities the teachers work closely with other members of the staff at the TPS.

During the CONTINUED ASSESSMENT phas of our model the teacher is involved in the process of evlauations that include the TPS staff, parents, daycare consultants, and daycare staff. Regularly scheduled meetings will all these people provide the mechanism thru which evaluations are made. Teachers at the TPS

meet daily to discuss their treatment plans for each child in relation to b his present status. Comprehensive reports on objectives, techniques, and effectiveness are written at least three times a year. The social worker meets each week with parents and the teacher joins these conferences once a month or more often if necessary. In order to update contracts concerning treatment of children in daycare centers and to exchange information of these children monthly visitations are held either at the center or at the TPS.

Behavioral data on each child as categorized and defined by the Volenski Social Interaction Scale is presented five times a year to the total staff. This data is used to evaluate each childs progress. A teacher can request additional data counts on any child (or even herself) to get specific feedback that may be used in treatment planning or as information that indicates further testing needs to be done, e.g. neurological, medical, speech evaluations. Follow up on the children and parents is formally conducted by the research assistant according to our research design which will be presented later. Teachers make informal inquiries to new teachers and parents of children that have left the preschool.

Teachers are individually responsible to carry through and follow-up all special interest projects. For instance tutors recommend and help arrange future placements for parents and daycare centers whenever possible. Diagnosticians see that special remedial programs set up in day care centers get their feet off the ground and then provide consultation as required.

In summary I would like to reiterate that teachers at the TPS are now performing many roles both in and out of the TPS. We are expanding and see this expansion as a realistic response to the need to integrate the treatment of the child with his parents and the larger community. We also see ourselves providing services that may be described as preventative and not only remedial. We have some special and more [illegible] ideas we would like to share with you during the workshops that will follow. We truly welcome your ideas, criticism, and suggestions, particularly in the area of outreach activities where we are real novices. If you like, just browse or pick up some of our handouts.